

## Abstracts

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**CONCLUSIONS:** The EQ-5D was easily understood and accepted by this cohort of patients with ACS and can serve as a valid measure of health-related quality of life in ACS population-based studies.

**PCV36****THE IMPACT OF ACEI RELATED COUGH: A SURVEY OF AUSTRALIAN PATIENTS**

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**OBJECTIVES:** Cough is a widely recognised adverse effect of Angiotensin-converting enzyme inhibitors (ACEI) and has been linked to poor medication compliance and potentially poorer quality of life (QoL). Clinically, AIIRAs (Angiotensin II receptor antagonists) have been shown to reduce the occurrence of cough relative to ACEIs. This study was designed to determine the impact of cough on patients' QoL by using generic and cough-specific QoL measures and contingent valuation (CV) methodology. **METHODS:** Ninety-one patients currently on ACEIs and 48 patients switched from ACEIs to AIIRAs were recruited from across Australia. Both groups were asked to complete the World Health Organisation Quality of Life questionnaire (brief version) (WHOQoL-Bref) and to answer general questions on QoL, health and demographics. Those on ACEIs also completed the Cough-specific Quality of Life Questionnaire (CQLQ). A CV question, which gave the participants the choice between an ACEI and AIIRA level of cough, was also asked. The CV health states were based on clinical trial data. **RESULTS:** Respondents ranged in age from 38–81 years (mean = 58.4 years) in the ACEI group, and 31–82 years (mean = 55.6 years) in the AIIRA group. A significant relationship between cough severity and QoL existed for the CQLQ ( $p = 0.003$ ) and the WHOQoL-Bref ( $p = 0.025$ ) in the ACEI group. Cough severity was significantly related to difficulty of sleeping ( $p = 0.009$ ), being self-conscious ( $p = 0.015$ ), and exhaustion ( $p = 0.002$ ). The CV analysis for the AIIRA scenario yielded a mean willingness-to-pay of AUS\$16.80 per month for those on ACEIs and AUS\$16.20 per month for those on AIIRAs. **CONCLUSION:** Overall, the results from this study illustrate the impact that ACEI-induced cough has on quality of life. Both patient groups were willing to pay over AUS\$16 per month to experience effective hypertension control associated with a lower risk of experiencing cough. This suggests that the impact of cough on QoL may be more than previously considered and should be considered when selecting anti-hypertensive treatment.

**PCV37****HEALTH-RELATED QUALITY OF LIFE OF PATIENTS MAKING AN ATTEMPT AT SMOKING CESSATION**

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**OBJECTIVE:** To assess the acute effects of smoking cessation on health-related quality of life (HQL). **METHODS:** Questionnaires were mailed to patients enrolled in a smoking-cessation program just prior to quit date (T1) and 1-week post-quit (T2). HQL was assessed by the Smoking Cessation Quality of Life Questionnaire (SCQoLQ). It contains 5 cessation-targeted scales: social interactions, self-control, sleep, cognitive-functioning, and anxiety. The SF-36 is included as a generic core. Other data

included patient demographics, duration of smoking, Fagerstrom scale, and smoking status at T2. Student's t-test for paired data was used to compare the T1–T2 HQL scores. Student's t-test for independent samples compared the HQL of a higher addiction (HA) group (Fagerstrom > 6) to a lower addiction (LA) group (Fagerstrom ≤ 6). **RESULTS:** Respondents ( $n = 34$ , 12 in HA-group, 22 in LA-group) averaged 48.6 (+12.0) years of age and were primarily Caucasian (97%) and female (72.2%). The mean Fagerstrom score was 5.0 (+2.3). Overall, one week into cessation (T1 to T2) there was significant worsening in SCQoLQ anxiety ( $71.5 + 25.1$  to  $61.1 + 26.0$ ,  $p = 0.04$ ) and cognitive-functioning ( $72.2 + 20.4$  to  $61.3 + 23.9$ ,  $p = 0.02$ ) scores and improved self-control ( $46.5 + 22.2$  to  $5.1 + 18.5$ ,  $p = 0.001$ ) and SF-36 general health ( $65.2 + 18.4$  to  $70.5 + 16.9$ ,  $p = 0.01$ ). At T1, all LA-group HQL scores were higher than HA-group scores, significantly for sleep, cognitive-functioning, anxiety, and SF-36 role-emotional and mental-health. Between T1 and T2 there was significant decline in sleep, cognitive-function, and anxiety and improved self-control in the LA-group; the HA-group had significant improvement in self-control and SF-36 general-health, but no significant changes in other scores. All SCQoLQ scores at T2 for LA were higher than either the T1 or T2 SCQoLQ scores for the HA. **CONCLUSIONS:** Generally, HQL changes one-week into a smoking cessation attempt. Smokers with higher addiction have lower HQL when they begin their cessation attempt, while smokers with lower addiction have greater change in their HQL.

**PCV38****HEALTH-RELATED QUALITY OF LIFE IN AN ACUTE CORONARY SYNDROME POPULATION IS AFFECTED BY DEPRESSION TREATMENT ADEQUACY**

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**OBJECTIVES:** 1) To determine the prevalence of depression symptoms and to describe antidepressant treatment in a population with a history of ACS, and 2) To describe the relationship of depression treatment adequacy and health-related quality of life (HRQL) controlling for patient, treatment and disease characteristics. **METHODS:** All ACS-diagnosed patients discharged from a university-affiliated hospital during a 3-year period were mailed a survey that included the SF-8, EQ-5D and other self-reported measures of disease and treatment (e.g. physical functioning, comorbidity, medication compliance, perceived cardiac severity). Patients were categorized based on self-report of depressive symptoms and antidepressant medication. Adjusted mean HRQL measures were determined by least square mean analysis controlling for independent variables. **RESULTS:** Of 1217 patients, 490 (40.3%) responded. Respondents averaged 65.2 ( $\pm 11.3$ ) years of age; 71% male; 92% Caucasian; 64% with MI history; 17% had their most recent cardiac event within 6 months. No depressive symptoms and no depression treatment (without depression) were reported by 59.8%; 27.6% reported untreated depressive symptoms (untreated); 8.6% reported depressive symptoms and antidepressant medication (undertreated); and 4.1% reported no symptoms and antidepressant medication (adequately treated). Adjusted mean SF-8 Mental Component Summary (MCS-8) scores were 52.8, 52.5, 42.8, and 40.2 for patients without depression, adequately treated, untreated, and undertreated respectively ( $p < 0.0001$  for all pairwise comparisons except for patients without depression vs. adequately treated and untreated vs. undertreated). The only other significant pairwise HRQL comparison was between the adjusted mean general health VAS scores for nondepressed and

undertreated patients; there were no differences in SF-8 Physical Component Summary scores by group. **CONCLUSIONS:** Depressive symptoms are common in patients diagnosed with ACS and appear to be related to lower mental HRQL. Though the need for prospective analyses remains, these observations stress the importance of identification of depressive symptoms in this population and initiation of appropriate psychotherapeutic treatment.

## PCV39

**HEALTH STATUS IN HIGH-RISK PATIENTS UNDERGOING NONCARDIAC VASCULAR SURGERY IN THE UNITED STATES**  
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**OBJECTIVES:** To assess health status in high-risk patients undergoing noncardiac vascular surgery in the United States. **METHODS:** Health status data were collected as part of a pharmacoeconomic (PE) substudy from a clinical trial in noncardiac vascular surgery patients. The analysis population consisted of subjects (mean age = 70.0) from the primary clinical analysis population of U.S. subjects who consented to participate in the PE substudy. Health status was measured using the 12-item Short-Form Health Survey (SF-12 acute, version 1) at baseline and post-operative Day 30. Physical and mental component summary scores (PCS and MCS) were calculated using published scoring algorithms. **RESULTS:** Of the 370 subjects in the U.S. clinical population, 229 subjects (62%) provided information on the SF-12. Differences in the distribution of age, gender, race, and index procedures were similar in both clinical and PE substudy samples. Mean scores were 30.6 (SD = 10.7) at baseline and 32.8 (10.6) at Day 30 for the PCS; corresponding scores were 50.3 (12.4) and 50.4 (10.5) for the MCS. There was a slight improvement in the mean change from baseline for the PCS and no real improvement for the MCS. The proportion of patients whose SF-12 scores improved from baseline was 54.2% and 45.9% for the PCS and MCS, respectively. Mean baseline SF-12 scores on the PCS for these subjects were noticeably lower than those from the general U.S. population norms aged 65–74 (PCS mean = 43.9, SD = 9.3) and from other common chronic diseases. **CONCLUSIONS:** The data suggest a marginal improvement in PCS, but not MCS scores at post-operative Day 30. A longer follow-up may have been necessary to detect a noticeable improvement in health status. High-risk patients undergoing noncardiac vascular surgery have relatively low levels of physical functioning and well-being compared with many other diseases.

## PCV40

**ASSESSMENT OF THE QUALITY OF DRUG TREATMENT IN CORONARY ARTERY DISEASE USING QUALITY INDICATORS**  
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**OBJECTIVE:** Assessment of quality of drug treatment can be expensive and time consuming. Database of sickness fund was used and a set of non-specific and disease-specific indicators according to treatment guidelines was developed to assess the quality of drug treatment of coronary artery disease (CAD) in counties population. **METHODS:** Patients from 5 selected counties in Slovak Republic treated for CAD were identified from database of General Sickness Fund. Overall prescribed treatment for CAD in 2001 was assessed according to the quantity and quality of prescribed drugs using developed set of 10 quality indicators. **RESULTS:** A total of 52,487 patients (10.3%) were

treated for CAD, 65% were female. The mean age was 68.3 years. Seventy-seven percent were also receiving treatment for hypertension and 18% had diabetes. Sixty-five percent were treated with long-acting nitrates, and in almost 25%, long-acting nitrates were the only treatment for CAD. Sixty percent were not receiving beta-blocking agents. Antithrombotic therapy was prescribed for two thirds of patients. Only 15% were receiving hypolipidemic agents. Performance in each county using 10 quality indicators was assessed separately and huge differences between counties were found. **CONCLUSIONS:** The overall score achieved with quality indicators was unsatisfactory. The results show low compliance of physicians with existing guidelines and the need for activities for improving the quality of drug treatment of CAD.

## PCV41

**MEDICATION POSSESSION RATIOS FOR PATIENTS WITH CALCIUM CHANNEL BLOCKERS AND/OR STATINS**

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**OBJECTIVES:** The purpose of this study is to compare medication adherence in patients initiated on a combination therapy of Calcium Channel Blockers (CCB) and Statins with those on CCB or Statins mono-therapy. **METHODS:** Using pharmacy claims data of a California Medicaid population from 1995 to 2002, we computed a 90, 180, 270 and 365-day Medication Possession Ratio (MPR) for the purpose of measuring medication adherence. Four patient cohorts are compared: 1) CCB only (N = 33,367); 2) Statins only (N = 27,536); 3) Combination Therapy: CCB + Statin (initiated on CCB, Statin addition) (N = 14,866); and 4) Combination Therapy: Statin + CCB (initiated on Statin, CCB addition) (N = 5944). Patients with both a CCB and a Statin medication filled on the same day (N = 1265) are included in both Cohorts 3 and 4. Patients must have Medicaid coverage for at least six months prior to initial CCB or Statin medication use to be included in the analysis. Continued eligibility for an adequate length of time is required to compute MPR for given days (e.g., 3 months continued eligibility to compute a 90-day MPR). **RESULTS:** The average 180-day MPR was 54.5% for Cohort 3 and 52.1% for Cohort 4, which is lower than that of CCB and Statin mono-therapy (56.5% and 59.7%, respectively). However, the average MPR for the combination therapy increased to 64.4% with the addition of a CCB and to 65.2% with the addition of a Statin. In general, average MPRs increased over the years. For the Statins-only cohort, the 180-day MPR increased from 50.8% in 1995 to 64.2% in 2001. **CONCLUSIONS:** Multiple medications appear to reduce medication adherence. For patients using combination therapy of CCBs and Statins, it may be beneficial to develop a combination drug to improve medication adherence.

## PCV42

**PERSISTENCE AND ADHERENCE TO STATIN THERAPY IN A MANAGED CARE SETTING**

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**OBJECTIVES:** The goal of this study is to evaluate patient persistence and adherence rates to HMG-CoA reductase inhibitors (statins) in a managed care setting. **METHODS:** Retrospective claims analysis of a nationwide managed care pharmacy database was conducted for continuously benefit-eligible patients who were initiated on statin therapy from 1999 to 2002. Patients were tracked for 12 months starting from the date of initial